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Constructing and Sustaining Counter-institutional Identities

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Constructing and Sustaining Counter-institutional Identities

Abstract

How do individuals and collectives construct and sustain identities that run counter to dominant institutions? We develop the notion of counter-institutional identity as involving individual and collective constructions of ‘who we are’ that are in strong opposition to dominant values and principles in the field, diverge from roles that are established through socialization and training, and involve practices that are proudly construed in direct contrast to field norms. We draw on findings from a comparative case study of Assertive Community Treatment (ACT) teams to theorize about the identity work of groups and individuals that enables and constrains counter-institutional identity constructions. We develop a cross-level process model of encapsulation in which authoritative texts (or prescriptive documents) play a role in sanctioning and enhancing counter-institutional identities. The model shows how rigorous positioning against ‘who we are not’ (an “identity foil”) through practices of oppositional identity work are combined with practices of relational identity work that reinforce counter-institutional identities by positively valuing ‘who we are’ as superior to the foil. These practices are crucial to understanding how and why counter-institutional identities are created and sustained.

How do individuals and collectives construct and sustain “counter-institutional” identities that are in opposition to dominant values and principles in their field, run counter to their socialization and training, and entail practices that are proudly construed in direct contrast to field norms? This is puzzling given the dissonance that people are likely to encounter when they operate in settings where their work and sense of self stand in direct contrast to the dominant institution. Counter-institutional settings or forms of organization emerge when a set of people come to see a dominant institution as inappropriate, inadequate or unjust. For example, the creation of a free school that is counter to the traditional school system is based on the rejection of dominant values of hierarchy, control, certification and tradition (Grimes & Cornwall, 1987). Other examples of counter-institutional settings described in the literature include Christian fraternities in a secular college environment (Gurrentz, 2014), ecovillages in an urban environment (Ergas, 2010), and stigmatized consumption communities (Healy & Beverland, 2013; Kozinets, 2001).

As these disparate studies suggest, being broadly situated within dominant institutions while attempting to enact counter-institutional values, principles, roles and practices can be highly challenging (Ergas, 2010; Grimes & Cornwall, 1987; Gurrentz, 2014). For example, Grimes and Cornwall’s (1987) study of the failure of an alternative school showed the difficulty of sustaining the counter-institutional approach to schooling. Individuals and collectives that see themselves as acting in ways that run counter to dominant institutions are likely to experience struggles and tensions and engage in identity work to position themselves in counter-distinction to dominant models. Since counter-institutions exist in society and play important roles as spaces where people can challenge dominant principles and practices, we need to know more about how those who subscribe to these opposing forms construct and sustain their identities despite dissonance with dominant institutions. This is significant from both a theoretical and managerial

perspective, given the importance of identity constructions to how individuals and collectives make sense of situations and accomplish their work, with possible consequences for organizational outcomes.

However, the notion of counter-institutional identity (of individuals and collectives) has not been conceptually elaborated; neither have the dynamics underlying this type of identity construction and maintenance been adequately theorized. Even though scholars have become increasingly interested in identity construction in a variety of challenging situations, the ways in which individuals and groups take on and maintain a counter-institutional identity are likely to be different from these other situations. For example, previous studies of identity construction have considered situations in which people must cope with contradictory demands (Creed, DeJordy, & Lok, 2010; Reay, Goodrick, Waldorff, & Casebeer, 2017), deal with institutional change (Chreim, Williams, & Hinings, 2007; Kyratsis, Atun, Phillips, Tracey, & George, 2017; Lok, 2010) and adapt to career transitions (Ibarra, 1999; Pratt, Rockmann, & Kaufmann, 2006). We suggest that construction and maintenance of counter-institutional identity is different for the following reasons. First, it involves clear opposition to institutionalized models rather than compromise or reconciliation. Second, it does not imply a situation of change or transition. Counter-institutional identities stand in an enduring state of opposition to dominant identities and models, implying persistent “disidentification” (Elsbach & Bhattacharya, 2001). Hence, our research question is: *How do individuals and collectives construct and sustain counter-institutional identities?*

We investigate this question by focusing on the case of Assertive Community Treatment (ACT) teams. These teams provide mental health services according to an alternative model of care that stands in direct opposition to the mainstream medical approach of treating severe mental illness in psychiatric hospitals (Ontario ACT Association, 2017). ACT is a particularly

appropriate setting to study counter-institutional identity construction and maintenance because it exhibits the three dimensions that we propose define counter-institutions: (1) values and principles that run counter to those associated with the dominant institution, (2) roles that run counter to socialization and training, and (3) practices that are proudly construed in direct contrast to field norms. These practices may be seen as demeaning by those outside the counter-institution, and as such can be construed by others as involving dirty work (Ashforth & Kreiner, 1999). ACT team members provide services to individuals with serious and persistent mental illness, such as schizophrenia; they do so according to a clearly defined model of care that stands in opposition to the dominant approach. The primary goal of ACT teams is to help clients achieve recovery rather than merely provide symptom relief through medication; they deliver services in clients' places of residence instead of hospitals or other institutions. Professionals who are part of these teams perform work that other professionals consider demeaning (e.g. helping clients with housekeeping chores). ACT team professionals are also required to engage in generalist roles that diverge from the professional specialist roles into which they were socialized.

We used a qualitative case study approach to investigate four ACT teams and their members operating in three Canadian provinces. By comparing four sites, we observed how individuals and groups constructed and sustained counter-institutional identities with different degrees of coherence to the clearly elaborated model set by ACT team standards. Our study spanned different levels of analysis with a focus on identity work and the dynamics through which counter-institutional identities were constructed and sustained.

We contribute a conceptual model that shows how identities at the individual and collective levels are constructed and sustained, and we theorize the dynamics underlying these constructions. Specifically, we argue that counter-institutional identities are constructed and

sustained through a cross-level process of encapsulation in which authoritative texts (i.e. prescriptive documents) play a role in sanctioning, legitimating and enhancing counter-institutional identities; where designated roles presented in these texts build the mandate to pursue counter-institutional identity construction; and where a foil (“who we are not”) is constantly activated as an essential element of “counter-ness.” We explain the importance of distancing from the foil, while simultaneously holding it close as a reference point for claiming superiority. Specifically, we suggest that the combination of identity work practices that promote the exclusion of “who we are not” (oppositional identity work), and that provide mutual support for “who we are” (relational identity work) is crucial to understanding how and why counter-institutional identities are created and sustained.

IDENTITY WORK AND COUNTER-INSTITUTIONAL IDENTITY CONSTRUCTION

Identity and Identity Work

We view *identity* as a self-definition – an answer to the question ‘Who am I?’ or ‘Who are we?’ Identity motivates and is reinforced by actions, especially in the case of professionals, who “*are often defined by what they do*” (Pratt et al., 2006: 236); their identity constructions and work practices are closely intertwined (Chreim et al., 2007; Goodrick & Reay, 2010). We adopt a social constructionist perspective (Corley et al., 2006) in defining *identity work* as the range of activities individuals or collectives engage in to construct, maintain, revise, evaluate, or present their identity (Alvesson & Willmott, 2002; Schwalbe & Mason-Schrock, 1996; Snow & Anderson, 1987).

Previous studies show a variety of situations involving individual or collective identity work. For example, identity work is manifested in situations of contradictions, tensions and change that raise questions about self-positioning (Creed et al., 2010; Kreiner, Hollensbe, &

Sheep, 2006; Kyratsis et al., 2017). Identity work contributes to restoring coherence and integrity when dealing with tensions. Identity work can also be manifested in situations of stigma, such as that associated with “dirty work” (Ashforth & Kreiner, 1999: 415), race (Slay & Smith, 2011) or other features of a group or organization (Tracey & Phillips, 2016). In these situations, it usually involves forming closer alignment and pride in association with the stigmatized work or entity.

In addition, research shows that individuals and collectives may engage in identity work by defining themselves in part by “*who they are not*.” There has long been recognition that creating distinctions between the self and others (e.g., Albert & Whetten, 1985) is central to identity constructions. Moreover, Ashforth, Rogers, and Corley (2011: 1151) refer to the notion of *identity foil*: “*An identity foil exists where an entity defines itself at least partly in opposition to or as the antithesis of another entity*” (see also Ashforth & Reingen, 2014). Elsbach and Bhattacharya (2001: 395) use the term “disidentification” to refer to a similar phenomenon. In their examination of how individuals define themselves in antithesis to an identity attributed to a particular organization (the National Rifle Association) they found that individuals disidentify due to perceptions of negative organizational reputation or incongruence between organizational and individual values.

Another body of research that has considered the notion of “identity foil,” but using different language, is the social movement literature in which scholars have pointed to the notion of “oppositional identity” as a central concept in understanding social movement dynamics (Melucci, 1989; Snow & McAdam, 2000; Taylor & Whittier, 1992). For example, Taylor and Whittier (1992) describe how lesbian feminists countered the dominance of patriarchy by vilifying the male and creating gender boundaries that set out women’s standards as superior to men’s; maintaining this oppositional identity was critical to the movement. In addition, studies on identity in social movements have focused on the “identity work” required to recruit

participants and align individual and collective movement identities around oppositional identity frames (Hunt & Benford, 2004; Polletta & Jasper, 2001; Snow & McAdam, 2000). Although this work emphasizes discursive framing practices as the means for attracting recruits and achieving alignment (Snow & McAdam, 2000), the actors who do the framing have not been clearly delineated; instead, there are references to “the movement” (Snow & Benford, 1988), “adherents and activists” (Benford & Snow, 2000; Hunt & Benford, 1994) and “movement leaders” (Polletta & Jasper, 2001).

Finally Kellogg’s (2009) study, which draws on social movement theory, contributes to our theoretical foundations by showing in a comparative study how a group that successfully introduced change in operating practices developed an “oppositional identity” against the defenders of the status quo and a “relational identity” (a sense of self manifested in mutual support among members)¹, the second of which was missing for the unsuccessful group. However, this study did not examine how these identities were constructed, or how they could be sustained. Thus, although the social movement literature shares an interest in oppositional identities and identity work, it does not offer a complete understanding of how counter-institutional identities may be constructed and maintained in groups or organizations.

Identity and Identity Work in Counter-institutional Settings

Indeed, although some studies have considered settings that share the characteristics of counter-institutions as defined above, the term “counter-institution” itself has rarely been used in organizational literature, with a few exceptions. Wortham (2006) used this term in a study of education to refer to a “within–against” way of doing that stands in opposition and constant

¹ Our use of “relational identity” follows Kellogg’s (2009) definition of this term, which refers to a sense of self in relation to supportive others in similar work positions or situations. This is distinct from Sluss and Ashforth’s (2007) view of relational identity, which is predicated on the role relationships between two individuals such as manager-subordinate, and captures how two role occupants enact their respective roles vis-a-vis each other.

comparison to the dominant model of education. Symon, Buehring, Johnson and Cassell (2008) used the term when describing how some academic groups view qualitative research as a “counter-institution” informed by alternative sets of principles and practices that stand in opposition to the dominant quantitative research enterprise.

Other studies have referred to settings characterized by counter-cultural values that could be labelled counter-institutional such as alternative free schools (Grimes & Cornwall, 1987), religious fraternities in a secular environment (Gurrentz, 2014), and ecovillages (Ergas, 2010). These studies show that such settings emerge in opposition to dominant institutions that are seen as deficient in significant ways such as being unable to solve a given societal problem or espousing unjust practices. Some studies suggest that membership in counter-institutions involves positioning against dominant models, roles and practices. For example, Ergas’ (2010) study shows that ecovillagers’ principles run counter to the consumerist model that has limited regard for sustainability. Members thus enact unconventional *eco-roles* by proudly making their shelter and dumpster-diving for food. This and the examples mentioned earlier show a move to position the dominant institution (the foil) as deficient, and to position the self in roles that are more positively distinctive than roles in the dominant institution. However, surprisingly, these studies do not theorize counter-institutional identity and its construction and maintenance, or the role of the foil.

Pratt’s (2000) study of Amway, in contrast, provides an illustration of identity construction in what could be labeled a counter-institution. Amway, a network marketing organization, is a retail format that diverges sharply from retail’s institutionalized model. Pratt focuses on member identification and describes how recruits were sponsored by distributors who were adherents to Amway’s unconventional practices. The distributors influenced new members’ identity constructions by engaging them in *dream building* (helping recruits set goals and

cultivate desire for possessions) and *positive programming* (encouraging recruits to associate with supportive others). Of note, Pratt's study shows that these practices facilitated individual members' *social and ideological encapsulation*. Such encapsulation refers to the formation of strong in-group bonds whereby members spend increasing amounts of time with those who subscribe to the same belief system, buffering members from opposing views (Greil & Rudy, 1984; Pratt, 2000).

We find the studies by Ergas (2010), Pratt (2000) and other authors (Grimes & Cornwall, 1987; Gurrentz, 2014; Healy & Beverland, 2013; Kozinets, 2001) to involve settings similar to ours. However, although they all address tensions and challenges of maintaining a counter-institution, identity is not generally the main focus of analysis. Where identity does feature – as in Pratt's (2000) study – the focus is at a single level, stopping short of enabling an understanding of how individuals and groups jointly construct and maintain counter-institutional identities.

Cross-level Dynamics in Counter-institutional Identity Construction

The literature referenced thus far speaks to individual and collective level identity dynamics separately, however, it may be important to consider relations between the two especially in counter-institutional settings. Ashforth et al. (2011) describe identity construction at multiple levels as a structuration process in which the different levels enable and constrain each other. They suggest that intrasubjective cognitions about identity ("I") are shared through interactive processes, leading to a sense of intersubjective identity ("we") that can become reified in a collective identity (Ashforth, 2016; Cornelissen, Werner, & Haslam, 2016).

The notion of "identity regulation" is a concept that could be used to analyze cross-level identity construction and may be particularly relevant in counter-institutional settings. Identity regulation has also been referred to as identity pressures, prescriptions or conditioning (Alvesson

& Willmott, 2002; Gioia, Patvardhan, Hamilton, & Corley, 2013; Lok, 2010). The term refers to managers' or others' attempts to influence employees' identities through more or less intentional practices, such as providing a vocabulary of motives or defining the social space (Alvesson & Willmott, 2002). Some literature suggests that a group can regulate identity – its own and its members' – through group identity work involving processes of “defining, coding, affirming, and policing” (Schwalbe & Mason-Schrock, 1996: 113).

Reaching beyond group identity regulation, organizational and institutional discourses can regulate identities by encouraging specific conceptions of the self (Gagnon & Collinson, 2014; Wieland, 2010) or offering identity frames (Snow & McAdam, 2000). At this level, the notion of *authoritative texts* (Kuhn, 2008) has been proposed as a reference point encouraging or disciplining actors to adopt particular views of their identities, roles and practices. The existence of authoritative texts is evident for at least some of the counter-institutional settings described earlier. For example, Kozinets (2001) shows that Star Trek's utopian text is taken up by fans in their identity constructions in opposition to imperfections of the extant social world (positioned as the foil). If they exist, such authoritative texts may serve paradoxically as a means to institutionalize, to some degree, counter-institutional values, roles and practices even as they position them in opposition to a dominant institution. Additionally, individuals and groups can react to organizational and institutional pressures, incorporating or resisting identity prescriptions (Chreim, 2006; Langlely et al., 2012).

In sum, we argue that in counter-institutional settings where values, principles, roles and practices stand in strong contrast to those of the dominant institution, identity at the group and individual level is important but understudied. Although a few scholars have investigated situations where counter-institutional organizations exist, there has so far been little attention to how identities within such settings are constructed and sustained. Thus, we engaged in research

guided by the following question: How do individuals and collectives construct and sustain counter-institutional identities?

METHODS

We used a qualitative multiple case study design (Eisenhardt, 1989) that enabled us to compare identity construction across settings, enriching and contextualizing our explanations (Miles, Huberman, & Saldana, 2014: 101). This study is part of a larger research project investigating the dynamics of interprofessional collaboration in 11 mental health care teams, only four of which are ACT teams and are the subject of the current paper. The other teams were situated in primary care, mental health consultation, child psychiatry and addictions. Two publications use other data we gathered on ACT teams. Chreim, Langley, Comeau-Vallée, Huq, and Reay (2013) investigate the boundary work of leaders in four teams, only one of which is an ACT team. A second paper (Chreim & MacNaughton, 2016), geared towards a health care management audience, addresses distributed leadership in four teams, only two of which are ACT teams. Overall, the broader research project facilitated attention to the distinction between ACT teams and other mental health teams. In the next subsection, we report on the four ACT teams that are the focus of this paper by explaining our research context, data collection, and data analysis.

Context: ACT and Its Framework

ACT teams focus on maintaining clients in the community despite the severity of their mental illnesses. In Canada, ACT teams are affiliated with larger agencies, typically community health centres or hospitals, although they largely operate autonomously. ACT teams are expected to follow explicit “ACT Standards” which establish a significant contrast with values, principles, professional roles, practices and views of clients in the dominant hospital-based, medical model used for clients with severe mental illness. Each province has its own Standards (or Guidelines),

but the similarities are striking. Large sections of the Ontario Standards appear verbatim in the Quebec and British Columbia (BC) documents. Contributing further to the authoritative nature of these documents, the Ontario Standards acknowledge reliance on ACT Standards developed in the U.S. as a contrast to hospital-based mental health care “*after almost 20 years of field testing in various jurisdictions*”(Ministry of Health and Long Term Care, 2004).

We use the Ontario ACT Standards (hereafter *OAS*) to present the guidelines within which ACT teams operate. OAS states that because “*lack of strong fidelity to the ACT model*” is a reason for poorer results, the guidelines provide “*minimum Standards for program operations*” (OAS:1). The Standards prescribe values, principles, roles, identities and practices that teams and members should adopt: “*ACT staff must have attitudes and values that are compatible with ACT philosophy: compassion and respect for persons with severe mental illness...; understanding and belief in recovery concepts and clients determining their own goals*” (OAS:11). The Standards can thus be seen as a strong form of “identity regulation” through discourse.

According to the Standards, ACT teams constitute “***a radical departure from how traditional services are organized***” (OAS: 11; emphasis added). Specifically, the Standards place clients at the centre of recovery services: “*ACT serves clients... who, because of the limitations of traditional mental health services, may have gone without appropriate services*” (OAS: 4). “*Traditional mental health services,*” portrayed as deficient, are those typically delivered in hospitals. The ACT team helps clients achieve “*recovery*”, in contrast to the negatively referenced “*medical model*”: “*The overarching message is that... restoration of a meaningful life [is] possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a... spotlight on restoration of self-esteem*” (OAS: 38). Nevertheless, ACT teams are also required to have “*medication prescription [and] administration*” services (OAS: 11), under the supervision of a team psychiatrist.

Teams are explicitly defined in the Standards as including a psychiatrist, a team coordinator, nurses, a peer specialist and other clinical staff (OAS: 12). The team coordinator and psychiatrist “*monitor each client’s clinical status and response*” (OAS: 13) and together hold responsibility “*for supervising and directing all staff activities*” (OAS: 18). Specifically, “*the team coordinator has the responsibility to write policies and procedures for each of the areas identified in the Standards*” (OAS: 4). The peer specialist, in turn, is someone who has been “*a recipient of mental health services for serious mental illness*” (OAS:15), has a formative role in terms of educating the “*entire team*” on the importance of recovery, and whose “*services help clients identify, understand, and combat stigma and discrimination against mental illness*” (OAS: 27). “*A minimum of 1 FTE peer specialist... is required*” on each team (OAS: 15).

The Standards also refer to a “*generalist role*” (OAS: 14) – a term that our interviewees used extensively and that refers to the expectation that “*ACT team members’ roles are interchangeable when providing services to ensure that services are not disrupted due to staff absence*” (Ontario ACT Association, 2017). Interchangeability of roles implies that all professionals perform, with few exceptions, similar (generalist) roles. Given the well-known hierarchical stratification of professional roles in health care, this is a requirement that diverges sharply from dominant expectations (Abbott, 2014; Freidson, 2001). The Standards are also normative of group processes, stating that “*The ACT team shall conduct **daily organizational staff meetings**... per a schedule established by the team coordinator,*” (emphasis in original), even prescribing a specific agenda that includes a daily status review for all clients (OAS: 17).

In sum, the ACT Standards provide clear directions for groups and individuals. These “authoritative texts,” legitimize values, principles, roles and practices that stand in direct contrast to the dominant model. Teams that follow the ACT model are expected to closely adhere to these principles and practices in ways that could be considered institutionalized within the ACT

community. However, because the ACT model is situated within the dominant institution of mental hospital-based care, where principles and organization are “*radically*” different, drawing on professional staff whose training and socialization are structured by that dominant institution, ACT understandings and practices cannot be taken-for-granted, unlike dominant institutions (Phillips, Lawrence, & Hardy, 2004). This is evident in ACT members’ continuous identity work aimed at constructing and sustaining the counter-institutional identity (as shown in the Findings), a process unnecessary in the dominant institution of hospital-based mental health treatment. ACT also stands in contrast to community mental health models, where professional hierarchy is respected, and professional roles rather than “generalist roles” are practiced. Thus, we see ACT as a counter-institution that exists in distinct contrast and in opposition to the dominant institution of hospital-based mental health treatment.² Table 1 contrasts these two models.

Table 1 about here

The Cases: Four ACT Teams

We studied four teams: Alpha, Gamma, Delta and Omega (see Table 2) operating in three Canadian provinces: Ontario, Quebec and BC. All attempted to follow the ACT model, providing services to clients with severe and persistent mental illness. All teams included physicians, team coordinators, nurses, social workers and mental health counselors; all had or added peer specialists during the study, and most employed occupational therapists, addictions counselors, and other occupations. Teams in different provinces were selected to understand

²Note that health care settings are well-known for their highly stratified professional distinctions, with long-standing tensions around medical and psycho-social approaches to care which oppose doctors (and to some degree nurses) on one side, against social workers, psychologists and other professions on the other (Huq, Reay & Chreim, 2017). Considerable research has pointed to the hierarchical power relationships among professions and the role of narrowly defined professional identities in orienting care and patterns of interaction among professional groups in the health care system. These approaches and the hierarchical distinctions are indeed highly institutionalized for the different professions. Part of the originality (and counter-institutional aspect) of ACT lies precisely in the integration and flattening of these professional distinctions. Members tend to adhere to an ACT generalist identity rather than primarily to a professional identity (despite their highly specialized training), and their work practices reflect this polyvalence (e.g., allowing social workers to deliver medications, and nurses to engage in work that would normally be done by social workers).

similarities and differences in identity constructions. While the teams all used the ACT Standards as a reference point, as we shall see, they varied in terms of strength of their counter-institutional identity constructions.

Table 2 about here

Data Collection

Five researchers participated in three data collection procedures as shown in Table 2. We conducted open-ended semi-structured interviews with almost all the members of the teams with a few participants interviewed more than once. Interviews lasted from one to two hours each and addressed questions related to the team, such as its history, values, and what made the team similar to or different from other teams and mental health models. We asked about individual members' background, values, roles, practices, relationship with other team members, targets of identification, and how the individual positioned him/herself with respect to his or her profession and with respect to the team. In early interviews, we became aware of the distinctive character of ACT teams and added probes on how team members positioned themselves with respect to the ACT model. All interviews were recorded and transcribed verbatim. We also conducted non-participant observations of client review and administrative meetings during which we took notes on discussions, interactions, and positions taken by individuals and collectives. Documents analyzed included ACT Standards for each province and team documents. The researchers convened on a regular basis during data collection to ensure that comparable data were obtained.

Data Analysis and Presentation

We engaged in within-case analysis followed by cross-case analysis (Eisenhardt, 1989). For each case, observation data and interview transcripts were coded by one researcher who initially used descriptive categories mostly reflecting themes in the interview protocol (Miles et al., 2014). The researcher then produced a detailed description for the case. The researchers met

regularly to discuss data coding and emerging themes iteratively with reading potentially relevant literature (Miles et al., 2014). We all participated in coding data and crafting case descriptions.

Our early work with the data revealed that the four teams positioned themselves differently in relation to the counter-institutional ACT model. To analyze these differences, we reviewed the interview and meeting data for each team and compared the way in which members constructed their identity, noting also how and when they related to the ACT Standards. For example, when a participant made a particular identity claim (e.g., that the team subscribed to the recovery approach), we reviewed the text of other interviews to determine if this was corroborated by other members. We then reviewed the meeting notes, attending to the language used to talk about clients (e.g. “clients” or “patients”), and the decisions reached regarding treatment (e.g. prioritization of the client goal or the provider goal; extensive reliance on medication or psychosocial approaches). We used tabular arrangements to organize our analysis (see Table 3). By comparing the four teams’ identity constructions, we found that one team presented itself as “exemplifying” ACT principles, two teams viewed themselves as “becoming” exemplary ACT teams, and one team saw itself as partially aligned with the ACT identity (“approximating” ACT). This team, unlike the other three, showed divergent identity constructions among team members.

The next step involved understanding the identity work underlying these identity positions. The data indicated that identity work took place both at group level and at individual member level, and that these two types of identity work were mutually constitutive. For analytical purposes, we separated the levels, designating group level identity work as involving action by the collective. An example comes from a group meeting where we observed the *group collectively* chastising a member for violating the ACT Standards upheld by the group. This type

of identity work both affirms identity constructions at the group level, and regulates the identity constructions of the member. An example of member identity work is *an individual* self-selecting into the ACT team because of affinity with ACT values. Although this work occurs at the member level, it contributes to constituting collective identity by shaping the composition, views and practices of the group.

In analyzing the data, it became clear that three types of team members play a more significant role in counter-institutional identity constructions than others because they are “carriers of authority” within the team due to their positions, as recognized explicitly in the ACT Standards (the “authoritative text”). First, because they are situated at the top of the professional hierarchy, the team psychiatrists are “carriers of professional authority”. Second, due to their recognized coordinating role, team coordinators are “carriers of administrative authority.” Finally, the “peer specialists” are “carriers of normative authority” because they represent the client for whom the teams exist and their role involves educating the team on recovery. Because of the distinctive influence of these three people both individually and collectively, we created a separate caption – “leader identity work” – where the term “leader” signifies the occupant of a role (a carrier of a particular type of authority), not a value judgement about their effectiveness. It was important to distinguish these individuals from other members in our analysis because of their unique positional resources to influence identity constructions. An example of leader identity work is hiring members who exhibit counter-institutional fit.

Overall, these analyses indicated that both intra-level and cross-level dynamics influenced identity constructions. The three categories of identity work (leader, group, and individual member) and their subcategories are shown in Table 4 with representative quotes. We engaged in progressive rounds of analysis across the four cases to identify and compare the nature of these identity work types. When we identified a theme in one case, we searched the

other cases for evidence of similar or different themes, attempting to explain differences (Eisenhardt, 1989). Use of multiple cases allowed us to strengthen understanding and explanation (Miles et al., 2014).

We adopted several strategies to establish trustworthiness (Lincoln & Guba, 1985). We involved multiple researchers, all well versed in qualitative methods, and engaged in discussions throughout the research process to achieve agreement concerning interpretations. We triangulated by using multiple data sources. We used member checks of our preliminary analysis by making presentations to each of the four teams and adjusting our understanding based on their feedback. Finally, we provide extensive data to substantiate our interpretations.

FINDINGS: COUNTER-INSTITUTIONAL IDENTITY WORK

In the findings, we first describe key dimensions of ACT counter-institutional identity as constructed by the four teams, positioning them along a continuum in terms of their appropriation of this identity. Then we examine the different types of *identity work* used to construct and sustain counter-institutional identity, again comparing the teams. Each section concludes with an analytic summary that foreshadows the theorization developed in the Discussion.

Exemplifying, Becoming and Approximating ACT as a Counter-institutional Identity

Drawing on the identity constructions of ACT team members in interviews, as well as the prescriptions of the ACT standards, we identified three key dimensions of the ACT counter-institutional identity that place it in tension with the dominant model (see Tables 1 and 3): a commitment to a recovery (vs. medical) orientation towards care; a focus on generalist (vs. specialist) roles; and pride in serving a stigmatized clientele in difficult circumstances. We view

Alpha as “Exemplifying ACT” with members showing very strong appropriation of ACT values, roles and practices. Gamma and Delta (“Becoming ACT”) were more recently founded teams, both striving towards ACT as a shared and aspirational identity yet to be fully achieved. Finally, while Omega defined itself formally as an ACT team, identity work here was fragmented and tensions were manifested internally within the team (“Approximating ACT”). Below we show how positioning vis-a-vis the ACT counter-institutional identity was enacted (further data in Table 3).

Table 3 about here

Alpha: Exemplifying ACT. Alpha team members saw themselves as a perfect match with the ACT approach. They continuously referred to the tensions between the ACT model and the hospital-based model, clearly viewing the latter as an identity foil. Identity work in Alpha was aimed at sustaining a counter-institutional identity despite tensions with the dominant medical model. Alpha members gave prominence to recovery (vs. treatment), and highlighted their distinction from the dominant model that was portrayed as highly deficient for the clientele:

In general, in hospitals, you have a very objectified view of patients and very traditional view of illness. It's sort of narrow, binary, sort of pseudo-scientific view of mental illness and patients not having many rights or not being capable. (Psychiatrist, Alpha)

We help people with their medication... to help manage chaos and when people aren't well, but then we pull out... and would like our focus to be on rehab and recovery, and get people to live a life that's more enriching than it has been. (Team coordinator, Alpha)

Alpha members positioned themselves as generalists, following the Standard's prescriptions and counter to professional roles, authority and hierarchy typically prevalent in hospitals. When asked about her role, a nurse described it in generic terms with limited reference to her specific professional expertise, and added “*On our team, we all share a lot of the same responsibilities.*” Contrasting her work in the ACT team with work at the hospital, she said:

In a hospital, there's a hierarchy of positions. The doctor is king or queen, and everybody below him or her is just following those orders. The focus is more on medication and symptoms. [When I was at the hospital,] my client wanted to see a spiritual guidance person. I was told to ask the psychiatrist. The psychiatrist said 'No'... You have an idea that might help somebody and you can't follow through on it. (Nurse, Alpha)

She positioned the team against and as superior to hospital-based models that adhere to hierarchical roles and adopt medical approaches unheeding of client wishes.

Identity constructions at Alpha also showed particular pride in genuinely touching the lives of a stigmatized clientele, in contrast to the “*standard*” approach: “*It’s not that the client comes to your office and you try to pretend that you’re doing something about their lives.*” The team coordinator described members as advocates for stigmatized clients: “*Team members are amazing at advocating for clients with employers, universities... to ensure that people's rights are met.*”

Gamma and Delta: Becoming ACT. In contrast to the exemplary case (Alpha), Gamma and Delta were aspirational teams attempting to become ACT, and building a stronger counter-institutional identity. In Gamma, interviews suggested an early, fragile counter-institutional identity. Specifically, Gamma was initially established as a joint venture between a hospital and a community organization. Conflict between the norms of these two organizations (around the emphasis on recovery vs. medical orientation) led to a break-up and a period of reconstruction. At the beginning of the study, the reconstructed team relied on a small core of professionals who had been present since team foundation. Around this nucleus, however, staff turnover was high:

We are lucky to have people with maturity and amazing ACT clinical competence. We are trying to complete our overall team with different experts to get to 10 professionals, and we’re talking about a peer specialist... We don’t have one yet. (Team coordinator, Gamma)

The Gamma team coordinator also spoke of a “*strong ACT culture*” in the core team, indicating commitment to the Standards. Core members defined themselves as generalists (rather

than specialized professionals) and made dedicated efforts to support clients in the community, although they did not distance themselves as radically as Alpha from the medical approach. The team coordinator stated: *“ACT intervention is a continuum. It is treatment and rehabilitation. We do both... With clients as sick as ours, we need to find a mid-ground.”* In the first interview, the team coordinator described wanting to hire a peer specialist and other professionals who fit with ACT values. Later interviews, following the addition of a peer specialist and drug rehabilitation counselor showed enhanced pride and collective commitment to the counter-institutional identity, whereby the coordinator stated: *“I am really proud to be in an ACT team because we are really competent, we work well, and we are often proactive.”*

Delta was the youngest team in our sample, striving to ground their practices in the ACT Standards, and working toward full enactment of the model, as the team coordinator explained: *“The Standards have defined for us what the roles are. Housing, income assistance... other ACT teams are quite closely (aligned). So all the work we’ve been doing, it’s trying to make us fit.”* Interviewees at Delta explained their strong commitment to ACT and their work as importantly different from regular hospital care. A social worker stated: *“On our team, we’re really focused on rehabilitation. Most definitely we’re an alternative to a hospital setting.”* Since Delta was building up at the beginning of our study, we heard about some of the team dynamics that accompanied them learning how to become an ACT team, and their belief in ACT.

We have a team developing and figuring out how it's going to fit into the ACT norms. Lots of us have visited other ACT teams and then you bring those perspectives and standards back here – helping us follow the overall vision and principle of ACT. (Nurse, Delta)

By the end of our study, we heard that the team had moved to where they believed they were meeting the ACT standards and providing recovery-focused care.

Omega: Approximating ACT. Omega was the case where counter-institutional identity was least established. Omega prioritized the medical approach in group identity constructions, but some dissension was seen in members' positioning. The team coordinator lamented that "*We are more towards the stabilization end of the continuum*" referring to use of medications to stabilize symptoms, and a social worker stated: "*We had a visit from an ACT team [that] shifted far into the domain of recovery. Many of us, I for example, really liked their approach, but our team was not in a state to make any change.*" We also noticed that only some members – namely those who opposed the medical orientation – evoked the hospital with which Omega was affiliated as a foil:

Institutional (hospital) rules and vision... trickle down (to our team) and it's been a constant struggle to maintain a rehabilitation focus with the clients... ACT teams are really, really supposed to be client centred and the impetus for policies and procedures should come from that level, not the other way around. (Nurse, Omega)

Other members viewed hospital affiliation as opening "opportunities" for hospitalization of sicker clients seen as incapable of recovery, indicating stronger commitment to the medical model.

Despite the differences across the teams, we noticed that on Gamma, Delta and Omega, similarly to Alpha, the generalist role prevailed over the professional role in most members' identity constructions. These three teams also showed pride in associating with a stigmatized clientele but with less intensity than at Alpha, and with least intensity at Omega. We now turn to the types of identity work in which leaders, the group and individual members engaged and which enabled and constrained identity constructions. Further evidence for this analysis is provided in Table 4.

Table 4 about here

Leader Counter-institutional Identity Work

As stated above, we identified three types of leaders who were involved in counter-institutional identity work both individually and collectively. We now consider these leaders' identity work, attending to how their enactment of authority influenced group and member identity constructions. This was manifested in two ways: *modeling counter-institutional identity* through individual and collective practices; and *filtering membership of the team*.

Modeling counter-institutional identity. Psychiatrists represent and might enact traditional professional (medical) norms and hierarchies within ACT teams. Although the ACT model calls for democratic participation and an emphasis on psychosocial client goals, implying a shift away from traditional medical norms and hierarchies, this was not evident across all teams. The Alpha psychiatrist expressed weak identification with her profession. She was seen as highly collaborative, and as strongly espousing a recovery-orientation despite her medical background. She personally modeled a collaborative role that influenced other members:

I'm very weakly identified with my profession. Psycho-social problems are way over-medicalized. People say I'm a psychiatrist who thinks like a social worker. If you just did textbook psychiatry, I find it extremely boring and not that relevant. (Psychiatrist, Alpha)

(Our psychiatrist) is incredible, is extremely collaborative, is also very collaborative with clients, she doesn't impose. (Mental health counselor, Alpha)

Other leaders for ACT teams are team coordinators, whose roles are explicitly defined in the Standards, which state that coordinators write team policies and procedures consistent with ACT principles. These administrative leaders can have significant influence by modeling and encouraging others to emulate counter-institutional identity. On Alpha, the coordinator was a former hospital nurse who told us that she had come to disidentify with hospital nursing and its medicalized approach. Along with the psychiatrist, the team coordinator gave peer specialists a big say, accepting to learn from them about their experiences as patients in the mental health

system. Demonstrating the influence of these two leaders on Alpha, the peer specialist commented:

Who the coordinator is and who the psychiatrist is and their attitude and openness affects who they hire, and they would speak up and say 'We have to support the client'. I would definitely say it comes from them and then, their openness to listen to other people on the team too. Here, they're very open, they'll listen to others. (Peer specialist, Alpha)

While the psychiatrist represents *professional authority* and the team coordinator represents *administrative authority*, the peer specialist represents *normative authority* because of his or her educator role on the team and experiences as a client. The Standards specify that peer specialists are “*required*” on any ACT team, stating that their role involves educating the entire team on self-determination and recovery. The peer specialist’s influence on Alpha’s counter-institutional identity construction was a dominant theme, as every Alpha interviewee referred to her moving the team towards a recovery focused model.

Traditionally the system has been medical model... Part of the reason we've embraced the recovery model is we have the peer specialist, and part of her role is to introduce ideas to the team that as professionals we may miss... It's allowed me to understand better what it's like for someone within the mental health system, how they think and feel about themselves, and how what I do impacts that person. That position on an ACT team is really, really important. (Mental health counselor, Alpha)

We observed a discussion of housing options for a client in an Alpha team meeting where some members argued that the client’s health was deteriorating and she needed to move to supervised housing, despite her claim that she could take care of herself. The most vocal participant was the peer specialist, who passionately advocated for providing more support for the client to allow independent living, to which the team acquiesced. With this, the peer specialist modeled ACT identity. She both affirmed her own identity as a recovery advocate, and pushed the team to prioritize the client’s goal, consistently with a recovery-oriented identity.

While each of the leaders carries different sources of authority, and could contribute individually to counter-institutional identity construction and maintenance, their influence could

be mutually reinforcing or not depending on the relations among the particular individuals. As illustrated in the quote from the peer specialist above, at Alpha, the psychiatrist, team coordinator and peer specialist constituted a cohesive group that modeled identity constructions for other members in a synergistic way that was highly supportive of the ACT counter-institutional identity.

Similarly to Alpha, the psychiatrist and team coordinator in Gamma and Delta consistently and collectively modeled ACT identity. In Gamma, they did so by collaborating and conveying coherent orientations to the team. In Delta they met regularly, always focusing on ACT principles.

We usually see each other once a week to discuss the clinic and the team. We are good collaborators. We don't agree on everything, but we agree on the major orientations. We have honest discussions. It's important that we work collaboratively because otherwise it will show, and it will affect the team. (Team coordinator, Gamma)

The psychiatrist works with the team to manage clients - or to assist the team to work through times of crisis with people, because the main goal is to keep people out of hospital. We work together and ensure that we stay on the same page. (Team coordinator, Delta)

Thus, these leaders also modeled ACT identity by enacting collaborative interprofessional interactions, creating a distinction between their teams and the hospital model.

An evident difference in leader counter-institutional identity work between Alpha and the Gamma and Delta teams lies in the peer specialist's influence. Gamma had only recently hired a peer specialist, who was integrating into the team at the time of our later interviews. Although the potential of peer specialists to exert normative authority and model counter-institutional identity through client representation is strong (as in Alpha), this had not yet happened fully in Gamma. Furthermore, the ability of a peer specialist to exert that authority is not guaranteed by the role:

People caricature clients quite a bit and... sometimes it is tough to know whether it is sarcasm, mockery or caricature... I want to change this, but what do I replace it with? It plays a role in the team... to let off steam, a kind of bonding. (Peer specialist, Gamma).

Perhaps we don't use [the peer specialist] enough. Some team members had reservations about adding a peer specialist... Through his work and success with clients, he will be difficult to ignore. He is taking more space on the team. (Team coordinator, Gamma).

Delta had also hired a peer specialist whose influence had been felt on the group:

When we got a peer specialist, it made a big difference. This person is a non-degreed staff but they have a big role on the team because they're there to provide that lived experience perspective. (Team coordinator, Delta)

In Gamma and Delta, we see team coordinators facilitating peer specialists' normative leader role, without having yet achieved the level of modeling and cohesion evident in Alpha.

Omega offers the most striking difference from the other cases as it showed inconsistency between the psychiatrists and the team coordinator, especially regarding the modeling of recovery vs. medical approach. These differences created fragmentation in team identity constructions. Omega psychiatrists clearly oriented team identity towards a medical model:

Historically, we had two doctors who were very medically oriented... and it led to a very medicalized approach. Our current doctors are heavily associated with the hospital; the use of medications is seen as the main therapeutic approach, and neither practices psychotherapy. (Social worker, Omega)

The majority of our patients... hadn't taken treatment for a long time, so their illness or symptoms are much more pronounced, much more chronic in nature. So it's a little bit difficult to do rehab work with them. Although our intention is there to rehabilitate, many of these patients, it's not possible. They don't have the insight. (Senior psychiatrist, Omega)

The Omega senior psychiatrist told us that she saw no difference between her role on the ACT team and her role on the hospital psychiatric ward where she also worked. In the quote above, she talks about “patients” lacking insight – a view inconsistent with the Standards. In contrast, the newly minted team coordinator attempted to move the team towards a recovery orientation: “Recently we added a peer specialist and we're hoping to shift the team more

towards the rehab end of the spectrum". The peer specialist was added to the team towards the end of our study, but his effect had not yet been felt. The contradictory modeling of psychiatrists and the team coordinator led to divergent identity constructions across members, notably concerning the medical vs. recovery orientation, as an earlier quote by an Omega social worker indicated.

Filtering membership to achieve counter-institutional fit. Besides engaging in modeling, psychiatrists and team coordinators jointly held authority to make hiring decisions, through which they influenced the team's composition and orientation towards ACT principles and generalist roles. Alpha's team coordinator commented:

I hire very differently than I would have hired for a hospital. There is something about the personal suitability in this team. You cross boundaries between professions. It's the height of being able to collaborate with one another when you don't see that you're limited by a certain feature of what you've been educated for. (Team coordinator, Alpha)

Note the coordinator's reference to foils – hospitals and professional roles that are limiting.

Below, she describes how she evaluates job-seekers' reactions when hiring:

If you were a nurse, I'd ask you 'On a community visit, the client needs some motivational help around doing his dishes, would you talk to him, would you do his dishes?' It's amazing how many people... will say, 'I'm not there to do his dishes.' It's not about doing dishes, it's about modeling community living and what is manageable for the client. And every profession should be like that. (Team coordinator, Alpha)

Selecting and hiring was also employed by leaders on the other three teams as a way to influence identity constructions. We mentioned earlier the attempts by the team coordinators in Gamma and Omega to hire individuals (peer specialists and others) who would help move the teams closer to a recovery orientation. Delta's team coordinator noted, "*A couple of staff have moved on and we've really done a lot of work around recruiting individuals who seem to have a better fit for this kind of work with folks who are pretty marginalized.*"

Comparing the teams, we see that identity work by the three leaders in Alpha showed a cohesive effort to keep the team focused on counter-institutional values, roles and practices as specified in the Standards. Their work focused on *sustaining* a strong counter-institutional identity despite (or because of) tension with the dominant model. The Alpha team coordinator's quote on hiring shows the vigilance required to maintain a strong counter-institutional identity in the face of these tensions. In Gamma and Delta, the psychiatrist and team coordinator jointly promoted the ACT identity, and actively used hiring to achieve this. Their work involved *constructing* a stronger counter-institutional identity, potentially helped by bringing in peer specialists. In Omega, in contrast, efforts to influence identity construction diverged as the psychiatrists promoted the medical model, while the team coordinator attempted to move the team closer to the recovery model, and the newly-minted peer specialist had not yet exerted authority.

Analytical summary: The role of leader identity work in counter-institutional identity construction and maintenance: In sum, leaders within a counter-institutional setting can become major carriers of counter-institutional identity prescriptions, directly influencing group and individual identity constructions in part because their roles are structured by prescriptions in authoritative texts. As we suggested, leaders may engage in two forms of counter-institutional identity work: ***modeling*** counter-institutional identity, and ***filtering*** membership to ensure fit. Our comparative analysis further suggests that in counter-institutional settings, the more strongly members who carry authority in the team collectively and coherently model counter-institutional identity and maintain contrast with the dominant institution as a foil, the greater their influence is likely to be on collective counter-institutional identity constructions. Similarly, the capacity and willingness of leaders to filter out members who are unlikely to become socialized into the counter-institutional model helps to build and sustain counter-institutional identity constructions,

despite ongoing tensions with the dominant model. By engaging in these practices, leaders combining different forms of authority (legitimized in an authoritative text) jointly construct tighter boundaries around their group, distancing themselves from the foil of the dominant institution.

Group Counter-institutional Identity Work

In addition to the leaders' identity work, each ACT team also engaged in counter-institutional identity work as a group, partly constructing its own identity while regulating and enabling individual members' counter-institutional identity constructions. We identify two forms of group counter-institutional identity work: *regulating members' counter-institutional identity* and *bonding around counter-institutional identity*.

Regulating members' counter-institutional identity. Group identity work occurred partly in the context of Standard-prescribed daily meetings that offered a strong forum for mutual influence. In the case of Alpha for example, we observed a team meeting during which we saw group members chastising a counselor who had gone against the team decision to encourage a client to act autonomously. The team had decided earlier to encourage the client to take public transport, yet this counselor decided to drive the client to an appointment. To this, the counselor responded, "*Sorry, in both instances I went against the team,*" and promised to invest more time in encouraging the client to be autonomous. In the meeting, the group affirmed its recovery-focused identity, simultaneously regulating the individual to adopt recovery practices. In Alpha, the group also kept watch over transgressions to counter-institutionally prescribed language codes.

We're to catch each other on pejorative language or hospital language that is not very empowering to clients. Like 'compliance'. We never use 'compliance'; either people choose to take their meds or they don't choose to take their meds. (Psychiatrist, Alpha)

In the above quote, we again see the group sustaining a position that is explicitly against the dominant model: the team remains vigilant to ensure dissociation from hospital language presented as pejorative and disempowering of clients. Alpha members consistently upheld this position.

In Gamma and Delta, we noticed group regulation of identity constructions consistent with observations at Alpha. For example, at Gamma, a social worker explained how the group monitored a team member who had not followed the guidelines: *“I don’t think she did it in bad faith, but the team noted her deviation and reminded her of the guidelines. It was done in a supportive way, we adjust together.”* The group’s influence on individual identity constructions was also clear in Delta. For example, during a team meeting, a nurse reported that on a home visit, she decided to give the client medication for anxiety even though he did not want it. Several members questioned why she did this and pointed out that such action did not respect ACT principles. The discussion ended with the nurse agreeing: *“Thanks everyone, I learned a lot.”*

In Omega, in contrast with the other teams, we observed fragmented attempts at regulation of identity constructions of members. During team meetings, attempts to regulate, and the direction of regulation, varied depending on who was in attendance. For example, in a team meeting when the senior psychiatrist was absent, we saw some members – the most vocal being a nurse who had described herself as a proponent of the recovery approach – argue with the junior psychiatrist about the importance of giving more autonomy to a client. We observed that attempts to regulate were different when the senior psychiatrist was present and exerted her authority, typically moving team decisions closer to a client stabilization orientation (medical model) with limited resistance.

Bonding around counter-institutional identity. In addition to regulating members' transgressions, groups also offered support and bonding in relation to involvement in difficult work. Difficult work varied in form: an Alpha member referred to difficult work in the context of dealing "*with the outside world*" that denigrates ACT and its workers, and another informant spoke about dealing with difficult client problems. The psychiatrist described the situation:

You've got a cohort of patients, not very much turnover, very, very heavy load of psycho-social problems and sort of a social stigma and alienation. Then you've got this more or less stable cohort of a small group of clinicians... And then the frustrations of dealing with the social system... So it's heavy, heavy work, heavy emotional work. (Psychiatrist, Alpha)

In the face of difficult work, the group enabled individual members' enactment of the counter-institutional role by providing support and elevating members. We saw this during team meetings: whenever a member brought up difficulties faced with a client, a group discussion ensued that offered solutions and support. A mental health counselor spoke in an interview about the challenges: "*When you go to the client's apartment and it's infested with bedbugs, you just put your gloves on and you help the client clean the apartment,*" and then mentioned feeling a connection with other team members: "*We feel a bit special... This job is probably not for everybody*" – a proclamation of collective pride in enacting counter-institutional identity.

Collective bonding and pride was also clear in attempts to proselytize advanced ACT practices to other teams. Alpha subscribed to a highly elaborate view of the notion of recovery, associating it with consumer and client rights movements. Alpha members referred us to the *Principles of Psychiatric Rehabilitation* that address the importance of empowering individuals receiving mental health services. The team worked diligently to enact the recovery approach and members spoke with pride about their collective efforts, contrasting themselves with "other" less perfect ACT teams. They also engaged in proselytizing to other teams and the ACT community:

We're more ethical and less stigmatizing than other ACT teams... An example is that somebody from [another ACT team] was saying that they wouldn't allow a client to get married, whereas we would support our client in that or anything. (Peer specialist, Alpha)

[We] went to different ACT conferences in the States. We also presented to the Psychosocial Rehab on the recovery orientation. We've done a lot of work to support [the recovery focus], and we try to make that happen. (Nurse, Alpha)

In Gamma, Delta and Omega, our findings also show that the group offered opportunities for bonding and mutual support similar to Alpha. For example, a social worker in Omega stated:

We're very strong at covering each other's backs, if someone misses something, people pick it up or remind each other. As a group, we hold this redundancy to ensure things are done. So there's a lot of supporting each other. (Social worker, Omega)

However, in Omega, we did not see strong statements of group pride or collective attempts to proselytize. Although an older team, Omega showed no concern with spreading advanced ACT practices. In Gamma in contrast, we noticed that as the team moved to a stronger counter-institutional identity, strong proclamations of pride and instances of proselytizing appeared:

Before, we were seen as delinquent, because we did group interventions with clients (e.g., cognitive and behavioral group therapy). The National Centre of Excellence in Mental Health took their time to accept group therapy. Now, this is accepted. We got our way. Now, this is considered customary, part of best practices. (Nurse, Gamma)

Similarly, in Delta, the team became increasingly proud and showed bonding around ACT achievements. We observed a meeting during which there were statements of collective pride associated with a recent national workshop where Delta was viewed as a strong ACT team that others should emulate.

In sum, all four teams engaged in some forms of coherent group-level identity work, such as encouraging and supporting individual members' counter-institutional identity constructions. Alpha, Gamma and Delta showed strong pride in group accomplishments and engaged to varying degrees in proselytizing. These three teams also engaged in coherent efforts to regulate members,

while Omega's efforts in this regard varied according to who was in attendance at meetings and whose authority was exercised.

Analytical summary: The role of group identity work in counter-institutional identity construction and maintenance: Overall, these findings suggest that group identity work supports counter-institutional identity when a group engages in *regulating* members by screening *out* practices associated with the foil that do not conform to the group's understanding of its identity, and by *bonding* members together *within* that identity as a mutually supportive group that is special, proud and an exemplary carrier or contributing "author" of the authoritative text. These practices along with cohesive leader identity work of modeling and filtering contribute to enacting strong boundaries with the foil. On the other hand, half-hearted or sporadic regulating, perhaps provoked by dissension among leaders, weakens the sense of distinctiveness from the foil, enacting permeable boundaries with the dominant institution, and inhibiting the construction of a strong counter-institutional identity. The findings also show how an authoritative text that offers spaces for group identity work (e.g., by prescribing regular group interactions) may enhance the group's influence on counter-institutional identity constructions.

Member Counter-institutional Identity Work

Individual members also engaged in identity work that helped construct their own identity and influenced group identity construction. We identify two forms of member counter-institutional identity work: *reframing counter-institutional roles*, and *self-selecting for counter-institutional fit*.

Reframing counter-institutional roles. As mentioned, ACT members were expected to adopt the Standards-prescribed generalist role that departed significantly from institutionalized professional roles into which they were socialized. For example, a Gamma counselor commented, "*Installing plywood floor in a client's shed is a far cry from the traditional work of*

a drug addictions counselor”. The generalist role could be a source of tension. The psychiatrist at Alpha noted, “*You can get feeling a little bit anonymous with the blurring and diffusion of your professional identity because everyone kind of does the same thing.*” Enacting a generalist role implied that different professionals were mostly indistinguishable from each other (except for psychiatrists who could diagnose and prescribe, and nurses who could do injections). For example, when asked about her role, a Delta nurse described a set of practices that – with the exception of antipsychotic injections – were also enacted by members of other professions:

[My role] could be anywhere from giving somebody an antipsychotic injection, to taking somebody grocery or clothing shopping, to doing a budget with somebody... It may be looking at somebody doing laundry who hasn't been able to wash clothing for quite some time, who's homeless... It's really client-need directed. (Nurse, Delta)

In the face of this, we observed individuals across all four teams engaging in identity work by reframing and valuing the generalist role as “superior” to professional roles despite recognition that this departed from their prior experience and training, as a quote from an Omega professional illustrates:

On an ACT team, I have a specialty [occupational therapy] that only utilizes 30% of my time; the rest of the time I'm a social worker, I'm talking about medications. So you lose part of your identity as an OT in my case. It's not a problem for me. When I first started, my focus was always looking at occupational performance issues. The more immersed I became in ACT, it's natural now. I go in to visit a client and I've got much more things to focus on; do they understand their medications? What are the issues with their housing?... So it's more of a global approach. (Occupational therapist, Omega)

In their identity work, members constructed the generalist role as more self-enhancing, and associated it with comprehensiveness and more complexity than the professional role. Although participants pointed to a certain area of expertise that supported differentiation in the team, they constructed work identities largely in consistency with the Standards prescriptions. Moreover, some members, especially in Alpha, showed a militant stance in their positioning

against professionalized, hospital-based roles as illustrated in the following quote by a participant who reflects on the shortcomings of her former role as a hospital nurse:

As a [hospital] mental health nurse, you had some responsibility for helping people in terms of counseling but mostly it was monitoring... I experienced times when social workers would tell me that it was not my job to counsel, that I wasn't qualified. And it was very important for people, whether it was social work, psychology, that there was never any crossing of any boundary... Doctors too. I mean when I think now how rotely I would just do things, not questioning orders, not questioning treatment. (Nurse, Alpha)

Participants in the four teams made reference to their roles as involving working with a stigmatized clientele, with Alpha members addressing this issue with most intensity. An Alpha nurse stated: *"You see how society treats people with mental illness and the stigma that exists, and how people's rights are different when you have a mental illness versus not having one."* Participants dealt with stigma by wearing its badge and proclaiming pride in advocating for a clientele that faces extensive discrimination. Assuming the role of advocate was associated with construction of a valued counter-institutional identity. However, although many team members appropriated generalist roles and took pride in their unusual work with a stigmatized clientele, these roles and practices were not universally embraced. Those members who struggled with them either learned to self-regulate or left the counter-institutional setting, as we show below.

Self-selecting for counter-institutional fit. Members could strengthen or weaken counter-institutional group identity by self-selecting in or out of the team based on their identification with the recovery vs. medical model, their acceptance of generalist or professional roles, or on other aspects related to their personal engagement with the work. On all four teams, we were told about members who filtered themselves in or out. The following Alpha interview excerpt illustrates self-selection out of the team by individuals who do not embody the counter-institutional identity:

Psychiatrist: You have to think, what are we here for?... The trans-disciplinary nature helps clients because you're not chopping the client up in different parts, so each person

connects with the whole client and all their problems... You're not here to prove that your discipline is important.

Interviewer: Have you found situations where the professional background has been problematic?

Psychiatrist: Well it has been, but they've left.

We encountered a situation in Omega where a recreation therapist (RT) expressed concern about atrophy of her professional expertise and not meeting requirements of her professional designation:

RT: The biggest issue is I don't get to do much recreation therapy so I'm not keeping up as I should with my requirements as a rec therapist. My skills as a rec therapist haven't developed a lot since joining the team because I haven't had the opportunity to do that.

Interviewer: Is this a problem?

RT: Yeah it is, it's something that I've talked to the coordinator about.

This participant left the ACT team during the study and joined a hospital, where her professional expertise was valued. Others self-selected into the ACT team because they identified with the ACT model. A mental health counselor in Alpha expressed this as follows: *"The philosophy of practice of the team fits very well in my philosophy of practice as a personal counselor"*. Individuals who embodied "superior" ACT values self-selected into the team, helping construct the team counter-institutional identity in opposition to the dominant model. The Delta team coordinator stated: *"Our team is always advocating for clients and we've got strong personalities on our team and maybe this kind of work is attractive to those strong personalities."*

Members who self-selected into ACT teams tended to self-regulate according to counter-institutional prescriptions. This was particularly clear in the data from newcomers. For example, a nurse who had recently joined Alpha after working in a hospital positioned herself within the counter-institution and against the hospital, which she presented as deficient:

Here it's 'client', [not patient] and you wouldn't say 'compliant' because that isn't the best way of putting it. I had to learn what [recovery focus] was, but once I got it, I believe in it a lot more than the way things went at the hospital. (Nurse, Alpha)

Similarly, a new member on Gamma explained: “*I watch how the team members interact and work, to see what an ACT team really is. There is a framework that I know I must respect.*”

In sum, member counter-institutional identity work on all four teams involved reframing and appropriating counter-institutional roles and practices as sources of pride, and self-selecting or self-regulating according to counter-institutional prescriptions. Alpha differed from the other teams in terms of its members’ militancy against dominant professional, hospital-based roles, and the intensity with which they spoke about clients whose rights had been denied.

Analytical summary: The role of member identity work in counter-institutional identity construction and maintenance: The findings above suggest that for counter-institutional identity constructions to be sustained, they need to be appropriated by individual members. We see how in the face of tensions between dominant institutions and ongoing pressures from leader and group identity work that constrains them (leader filtering, group regulating) yet supports them (leader modeling, group bonding and proselytizing), members are likely to engage in ***reframing*** discrepancies with roles and practices into which they were originally socialized, taking pride in their difference, and finding value in aspects that most would view negatively, but that are shared and glorified within the group. Unity around counter-institutional identity constructions is also sustained by members ***self-selecting*** into and out of the group as a function of their ability to incorporate discrepancies with the dominant institution into their identity. The more consistent the pressures from ongoing leader and group counter-institutional identity work, the stronger the boundaries around the team, the more likely it is that the members who elect to remain within the group are those who fully appropriate counter-institutional identities. Inconsistencies in these pressures, on the other hand, are likely to result in unresolved tensions for individual members.

DISCUSSION: TOWARDS A MODEL OF COUNTER-INSTITUTIONAL IDENTITY CONSTRUCTION AND MAINTENANCE

Our aim was to understand how individuals and collectives construct and sustain identities that run counter to dominant institutions. We analyzed identity work by leaders, groups and individual members that enables and constrains counter-institutional identity constructions, and we considered synergy and disparity within and across levels of identity work. In this section, we draw together the concepts developed in the findings, and develop an overarching theoretical model, summarized in Figure 1, with key elements further elaborated in Table 5 and Figure 2.

Our overarching model (Figure 1) first shows the influence of authoritative texts that help structure and define the values, principles, roles and practices in the counter-institutional setting and provide specific identity prescriptions. When these prescriptions are appropriated by leaders, the group and individual members, we argue that a strong counter-institutional identity can be constructed and sustained through the mutually reinforcing identity work of modeling and filtering (by leaders), regulating and bonding (by the group as a collective), and reframing and self-selecting (by individual members). The figure also shows how counter-institutional identity work positions identity relative to and against the identity foil (portrayed by the arrows pointing out towards the dominant institution), as leaders, the group, and individual members situate identities in opposition to the dominant institution.

Figure 1 about here

We now elaborate on this model, focusing first on the role of authoritative texts, second on the multiplicative and synergistic role of identity work at different levels, and third on the role of the identity foil and processes of encapsulating that help explain the strength of counter-institutional identities and how they can be sustained. As we proceed, we build theory about

counter-institutional identity construction by focusing on the cross-level dynamics at play. Our perspective aligns with recent calls for cross-level studies to improve our understanding of identity construction processes (Ashforth et al., 2011; Gioia et al., 2013).

Authoritative Texts as Resource and Constraint for Counter-institutional Identity Work

The notion of the authoritative text (Kuhn, 2008) that formalizes counter-institutional prescriptions is an important aspect of the model, as this acts as a resource and a constraint for identity constructions (Chreim et al., 2007). We contribute by showing how such texts can sanction the social category (Glynn, 2008) constituted by the counter-institution, despite its divergence from the dominant institution. There is evidence that authoritative texts play an important role not only for ACT teams but also in other counter-institutional settings. For example, Gurrentz (2014) refers to “moralistic bylaws” that reinforce the distinction between the religious fraternity he studied and the dominant culture, and that function as accountability mechanisms ensuring members engage in behaviors consistent with their religious identity. We argue that authoritative texts (such as standards, books, videos, or other referential artifacts) reinforce the distinction between the identity of those inside a counter-institution and those in the dominant institution, and incite members to adhere to desired roles and practices, constructing their identity accordingly. We suggest that written or material forms of text may be particularly critical when the counter-institution is dispersed across many locales (cities within provinces and states) because it can be consistently referred to and enacted over time and place (Cooren, 2004).

Our study also suggests that authoritative texts can influence identity constructions *directly* as members mobilize them and appropriate their prescriptions in their own identity work, and *indirectly*, by conferring authority to certain roles (or “subject positions,” Hardy & Maguire, 2008) and prescribing practices favoring particular forms of group interaction. In the case of ACT teams, for example, the three leader roles were constituted in the ACT Standards,

legitimizing modeling and filtering work. The Standards also prescribed daily team meetings that served as a space for group identity regulation and bonding. Authoritative texts thus provide both direct and indirect support for counter-institutional identity construction and maintenance. However (as the Omega case showed), they may not be sufficient. Authoritative texts offer affordances for counter-institutional identity construction but their prescriptions may be enacted in practice with more or less completeness and coherence. We return to this when we discuss the third element of the model.

Synergies among “Oppositional” and “Relational” Forms of Identity Work

Figure 1 highlights the importance of cross-level identity work dynamics in understanding how counter-institutional identity constructions are sustained. We showed earlier how efforts by individuals (leaders and members) interact with and are mutually supported by the efforts of the group as a collective. Table 5 maps in a synthetic manner the six practices of counter-institutional identity work, illustrating the role that each plays in constructing and sustaining counter-institutional identity, while drawing on the authoritative text.

Table 5 about here

The arrows between identity work practices at different levels show their mutually reinforcing nature. For example, our study suggests that leaders’ filtering and modeling practices can enable consistent practices of regulating and bonding at the group level. In turn, when the group engages in regulating practices that orient members’ identity constructions, members will tend to take on similar identities or decide to leave the team. Those who stay are likely to reframe identity positively and to reinforce each other’s identities through bonding with other members.

Beyond these vertical relationships, when counter-institutional identity work at different levels are considered together, we see a duality emerging between identity work as a means of

regulation and control (filtering, regulating, self-selecting) *and* as a source of mutual support and co-elevation (modeling, bonding, reframing). The first set of practices handles tensions with the dominant institution by exclusion or constraint: values, principles, roles, practices, even people associated with the dominant institution (the foil) are squeezed out. The second set of practices, in contrast, dissolves tensions by elevating counter-institutional values, principles, roles and practices as better or superior than the foil. We label these two complementary sets of counter-institutional identity work practices “oppositional identity work” and “relational identity work” (see Table 5).

Importantly, we argue that together these two sets of identity work practices synergistically reinforce counter-institutional identity constructions. These notions build on Kellogg’s (2009) distinction between “oppositional identity” and “relational identity,” but transpose them to the context of identity *work*. We argue that the duality and complementarity created by oppositional identity work that promotes opposition against “who we are not” and relational identity work that promotes mutual support around “who we are” are critical in theorizing how and why counter-institutional identities are created and sustained.

On the controlling side, the importance of group identity regulation is aligned with findings from other contexts where group members signal to each other acceptable ways to present oneself (Karreman & Alvesson, 2001; Wieland, 2010). Concertive control (Barker, 1993; Tompkins & Cheney, 1985) over individuals emanates from consensus on values, practices and identities to be adopted by members, who self-manage to adhere to the group’s requirements. On the other hand, supportive group level identity work is important in situations of stigma, whereby what is painful at the individual level is converted into a source of pride at the group level (Brewer, 1991). Our findings give empirical support to these notions. But, more so, our contribution lies in recognizing how *both* oppositional and relational identity work dynamics are

relevant and complementary in counter-institutional settings, where the influence of the dominant institution looms large, and adherence to the counter-institutional model requires both control *and* support. We argue that defining identity *only* with respect to the negative (who we are not) is not enough; the work of modeling, bonding and reframing (who we are) is essential to sustain counter-institutional identity.

In contrast to oppositional identity work that protects the team from the intrusion of the dominant institution, relational identity work reinforces the team's beliefs in the value of its alternative model internally. We noted however, that proselytizing externally as a form of group bonding only occurred for the ACT teams with the strongest counter-institutional identities. Engaging in such forms of bonding is probably not possible unless the group has already developed a strong counter-institutional identity. Indeed, as the findings show, counter-institutional identities are not constructed and sustained with equal strength across all settings. This brings us to the final component of the model.

Foils, Encapsulation and the Variable Permeability of Counter-institutional Boundaries

The third element of the model on which we build a theoretical contribution concerns the identity foil and the process of encapsulation that enables and sustains the distinctiveness of counter-institutional identity. These elements allow us to improve our understanding of how and why some enactments of the same counter-institutional authoritative text may result in stronger counter-institutional identities than others.

The notion of identity foil has been proposed in the identity literature (Ashforth et al., 2011), but has been given only minimal attention so far. In our study, as shown in Table 5, the foil is important in two ways. First, practices of oppositional identity work emphasize the negative (who we are not), and exclude anything related to the foil. Second, practices of relational identity work emphasize the positive (who we are), defining this as superior to the foil.

“Who we are not” and “who we are” are shown as separated by the central oval boundaries in Figure 1. While Kellogg (2009) seemed to suggest that oppositional identity could exist without relational identity, our study shows that strong relational identity (emphasis on mutual support) and strong oppositional identity (emphasis on excluding the foil) go together and reinforce one another in counter-institutional settings. This observation emerges from the comparison of our cases. To better illustrate, Figure 2 displays diagrams showing the positioning of our four teams using the initial model of Figure 1 as a basic template.

Figure 2 about here

The synergistic effect of mutually reinforcing counter-institutional identity work practices among leaders, the group and individual members in creating strong, impermeable boundaries was particularly evident in Alpha. Reference to the foil (the dominant institution) was constantly present in this team. The ongoing salience of both “who we are not” and “who we are” suggests the importance of holding the foil closely while simultaneously separating from it as an integral part of identity construction and maintenance in a counter-institutional setting. There was, indeed, remarkably little within-group tension in Alpha, revealing how counter-institutional identity construction is very different from situations where competing identities must be balanced or reconciled (Creed et al., 2010; Kreiner et al., 2006). Instead, tensions in this counter-institutional setting were *externalized* against the foil, construed as sharply distinct. This is represented in Figure 2 by thick boundaries separating the counter-institutional group from the dominant institution shown in sharply contrasted shading. Similarly, although counter-institutional identity constructions were somewhat more tentative at Gamma and Delta, mutually reinforcing dynamics were certainly in play. The diagram representing these teams in Figure 2 is similar though with weaker boundaries and contrasts with the foil.

In comparison, Omega was traversed by significant identity tensions. The tensions between the counter-institutional model and the dominant institution were *internalized* within the group as the two contaminated each other through the conflicting identity work of its leaders, and the struggles of members to position themselves amid contradictory messages about who they should be. Omega was inconsistent in its oppositional identity work, as it did not fully exclude elements of the foil, and was consequently unable to generate the same degree of mutually reinforcing counter-institutional identity dynamics as seen at Alpha (and even Gamma and Delta). We show this in Figure 2 with permeable boundaries surrounding the team and no distinct shading to mark its separation from the dominant institution. As opposed to being firmly ensconced in the counter-institution, Omega sat on the periphery.

In other words, our contribution here is to indicate that enacting and sustaining a counter-institutional identity requires the creation of clear boundaries that allow the counter-institution to exist in its ideal form, without being corrupted by the dominant institution. This may be seen as a form of “encapsulation,” a notion used by other researchers to describe how organizations or groups control their members (Pratt, 2000; Pratt et al., 2006). Greil and Rudy (1984) refer to three forms of encapsulation: physical, social and ideological. We see mostly social and ideological encapsulation in the emphasis on the foil. For example, at Alpha, leaders, the group and members established mutually reinforcing identity constructions that socially and ideologically set themselves apart from others, “encapsulating” them as uniformly and collectively special. In contrast, for Omega, metaphorically speaking, the “capsule” (as illustrated in Figure 2) was breached. The dominant and counter-institutional models penetrated each other in such a way that members had neither a coherent positive identity target nor an obvious identity foil to refer to in constructing their identity.

The three diagrams in Figure 2 thus represent weaker to stronger illustrations of counter-institutional identity for the four teams we studied. In theorizing about the process of developing a strong counter-institutional identity, we suggest that the model on the left (representing Omega) shows a relatively weak identity construction because the capsule surrounding the counter-institution is porous, allowing identities associated with the dominant institution to persist. The middle diagram illustrates a stronger identity construction (Gamma and Delta) where many of the elements of counter-institutional identity are present, but where fragility of the capsule remains. The diagram on the right (Alpha) shows a very strong counter-institutional identity where the capsule is durable. We suggest that this illustration of similarities and differences in the strength of counter-institutional identities across our cases helps to explain the importance of different types of identity work in relationship to an identity foil. As part of the process of constructing and maintaining a counter-institutional identity, we point to the role of *encapsulating* – keeping clear separation from the dominant institution (through oppositional identity work) while also building supportive reinforcing mechanisms within the counter institution (through relational identity work). We do not suggest that there is a necessary progression from left to right; instead we believe that this presentation helps to show how counter-institutional identities may strengthen over time through ongoing oppositional identity work in concert with relational identity work.

Note in concluding this section that while the process of encapsulating we described here offers potential for counter-institutional settings to thrive in the midst of dominant institutions with which they are in opposition, that very possibility might be seen by some as problematic. The notion of encapsulation was originally used by scholars of cults and sects (Greil & Rudy, 1984), whose influence on members has not always been positive. We believe that ACT teams play a strong positive role as an alternative model of care for people who are often forgotten by

society. Yet the processes we have described could also be used in less laudable circumstances. Further research might examine in more depth the darker side of counter-institutional identity dynamics.

CONCLUSION

In this paper, we developed the concept of counter-institutional identity construction, a phenomenon that is particularly intriguing because it implies dissonance with dominant taken-for-granted norms and models, and therefore needs explanation. We drew on our data from ACT teams, and built on examples of other counter-cultural settings in the literature (Ergas, 2010; Currentz, 2014; Healy & Beverland, 2013; Pratt, 2000; Symon et al., 2008), to draw attention to common features of counter-institutions and explicate the connections with identity construction. Specifically, counter-institutional settings are associated with individual and group identity constructions that: (1) are in opposition to values and principles that are dominant in the field, (2) diverge from roles that are established through typical socialization, and (3) involve practices that are proudly construed in direct contrast to field norms. We view appropriation of these elements as defining “strong” counter-institutional identities. In addition to the settings we have mentioned, other cases where counter-institutional identity dynamics might appear include safe injection sites for users of illegal drugs, community policing that involves average citizens in making communities safer, and indigenous groups that set up models in opposition to dominant, colonizing institutions.

Our study contributes by establishing the notion of counter-institutional identity construction as a distinctive and important phenomenon for organization theory, and offers a model of how counter-institutional identity constructions may be developed and sustained despite or because of dissonance with dominant institutional models. We contribute to theory by

drawing attention to the role of mutually reinforcing cross-level identity dynamics and to the use of a foil as a crucial reference point for construction and maintenance of coherent counter-institutional identities among groups and individuals. We show how authoritative texts can offer counter-roles and practices to enable cross-level dynamics, and illustrate the complementary role of oppositional and relational identity work at multiple levels in excluding undesirable elements of the dominant institution, while reframing alternative values, principles, roles and practices as superior. Our analysis of four ACT teams reveals how these elements work synergistically together, and illustrates how they may fall apart when key components of the mix are missing.

Viewed more broadly, our focus on counter-institutional settings also sheds new light on the long-held understanding of identities as grounded in part in a sense of distinctiveness or difference. For counter-institutional settings, however, in contrast to other types of settings, the focus on distinctiveness or “who we are not” is particularly important and moreover, characterized not simply by construction of “difference” but by construction of direct “opposition” expressed in terms of the foil. Glynn suggests that organizations construct distinctiveness with elements drawn from their institutional environment (Glynn, 2008). In the case of counter-institutional settings, the emphasis on distinctiveness from the dominant institution might ultimately contribute to transforming it. Further research is warranted regarding how this might occur.

Before closing, it is important to identify possible boundary conditions and reflect on the transferability of our findings and theoretical model to other counter-institutional settings, given the specific nature of the health care context we studied. In particular, it is worth considering what elements might make our model more or less applicable. One such element is the degree to which the counter-institutional setting is localized or is part of a wider movement. ACT teams belong to an established counter-institution, and are framed by explicit standards and practices.

Although counter-institutional with respect to the dominant, hospital-based mental health care, they are also part of a wider movement that enables groups to lay claim to legitimacy because there are others like them. On the other hand, isolated or emerging counter-institutions might have a more idiosyncratic and fragile existence, and be more dependent on individual leaders, locally developed modes of practice (Ormrod, Ferlie, Warren, & Norton, 2007) and much tighter encapsulation of members in order for the collective's counter-institutional identity to be constructed and sustained. Indeed, this observation suggests an intriguing paradoxical phenomenon. As counter-institutional identities are reinforced, sustained and propagated in different locations, they may become to some degree "institutionalized" in themselves, even as they remain opposed to the dominant institution. Thus, what is counter-institutional may depend on the perspective taken. Moreover, as hinted at above, the existence of established counter-institutional pockets within a broader field might potentially seed deeper, long-term institutional change. Future research could explore this phenomenon in more depth.

A second boundary condition is the degree to which counter-institutional settings are oriented towards achieving social, other-oriented goals or are more internally self-focused. The case context we studied speaks to the emergence of a compassionate system of care nested within an environment that tends to objectify its clients. The capacity to build credibility around a foil as a contrasting reference point (oppositional identity work), and create a mutually supportive counter-institutional identity as superior in relation to a dominant institution (relational identity work) may depend in part on the degree to which members of the group can draw on the mobilizing effects of empathy for others (Lawrence, 2017), and build on this to mutually support each other as well. In contrast, several other counter-institutional settings we mentioned do not, at least at first sight, have a similar other-oriented perspective. Future research

might examine the differences that this makes for the sustainability of counter-institutional settings and identities.

Finally, we studied counter-institutional identity in the context of work groups, whereas some counter-institutional settings we mentioned are voluntary collectives that may or may not be associated with work (e.g. eco-villages, religious fraternities, consumer tribes). Some are also fully-fledged organizations in themselves (e.g., Amway; alternative schools). While we think our theorizing is likely to resonate within these other settings, further research is needed to examine precisely what difference this might make to the ways in which counter-institutional identities are constructed and sustained. One might consider, for example, the effects of organizational form (e.g., work group vs. organization vs. voluntary collective) on the role of authoritative texts, on the relative importance of identity work at different levels (e.g., leader filtering vs. member self-selecting), and more generally, on the set of identity work practices likely to be used to exclude elements of the dominant institution while supporting superiority to the foil.

Our study also has important managerial implications. Where a work group or organization is grounded in the adoption of counter-institutional principles, values, roles and practices, leaders and managers should be aware of the inherent challenges. Organizational or group members must engage in identity work to situate themselves in opposition to the dominant institution. Organizational leaders can facilitate such identity work by creating an environment where members see themselves as different, and yet also recognize this difference as a strength and a source of pride. In many cases of counter-institutional settings, authoritative texts (such as founding documents, organizational charters, or legislation) may guide member activities. We suggest that these texts can be developed and used by leaders to provide ongoing direction for different types of identity work. Leaders can help others to develop strong counter-institutional

identities in long standing arrangements such as we studied, or in situations of novel organizational forms that diverge substantially from institutionalized forms.

In conclusion, we point out the importance of improving knowledge about counter-institutional settings. We have shown how individuals and collectives can construct and sustain counter-institutional identities despite their dissonance with dominant institutional frameworks. Our conceptual model can serve as a foundation for moving forward theoretically, and we hope that other researchers will build on our ideas.

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Table 1. Dominant and counter-institutional models of mental health care

	Dominant model (Hospital-based mental health treatment)	Counter-institutional model (ACT)
Values and principles	The medical approach is valued. People with serious mental illness are treated in hospitals where main treatment approach involves providing medication and reducing symptoms. Authority rests with health providers, psychiatrist in particular.	The recovery approach is valued. People with serious mental illness are supported to live in their own community and offered recovery-oriented mental health services delivered to them where they reside. Authority rests with the client, who works in collaboration with providers.
Roles	Professional role prevails. Providers are socialized and trained to engage in specific roles defined by their profession. Professional boundaries delimit roles. Professional hierarchy is observed, with psychiatrist as main authority, and other providers following psychiatrist instructions.	Generalist role prevails. Providers from diverse professional backgrounds engage with similar and varied aspects of the client's situation including health, psychosocial condition and activities of daily living. Professionals work together with a peer specialist in collaborative relationships. Psychiatrist holds final authority on medication, however, all providers offer major input on decisions including medications and other aspects of client's situation.
Practices	People with severe mental illness are stigmatized. Services are provided to patients based on professional judgment of best practice because people with severe mental illness have limited capacities and rights. Typically, medications and treatments are prescribed by psychiatrists and delivered by other health professionals.	Providers attempt to buffer clients from stigmatization. Services are provided in discussion with clients so that professionals suggest or recommend particular treatment approaches, but clients generally retain final say. Practices must respect the belief that people with severe mental illness have ability to recover and have extensive rights. Client empowerment is a goal.

Table 2. The Teams and Data Sources

Team – province (data collection period)	Team affiliation and history	Number of members	Number of interviews (total number of pages of transcribed interviews)	Number of meetings observed (total number of pages of typed meeting observation notes)	Team documents consulted
Alpha – Ontario (2010-2011)	Team affiliated with a community health centre since its inception about 10 years before the time of the study. Team psychiatrist, coordinator and peer specialist had been with the team since its inception. Other members joined over the years, including some who joined more recently.	12	13 (281 pages)	5 (28 pages)	-Team brochure -Team procedures manual -Team website
Gamma – Quebec (2011-2013)	Team affiliated with community division of an integrated health organization. Team was founded as an inter-organizational partnership more than 10 years before the time of the study. The partnership was dissolved 2 years before the study, giving the team the opportunity to focus more consistently on the ACT model.	13	16 (453 pages)	4 (43 pages)	-Team video -Team evaluation reports -Team website
Delta – BC (2010-2013)	Team affiliated with community mental health and 1 year old at the beginning of data collection. Team psychiatrist and coordinator were with the team since its inception. Peer specialist joined after first year. Other positions were consistent, with some transition in individuals filling those positions. The team had consistent membership by end of study.	12	12 (290 pages)	4 (26 pages)	- Team brochure - Team procedures manual -Team website
Omega – Ontario (2011-2012)	Team affiliated with mental health hospital since its inception about 10 years before the time of the study. Team historically and until time of study dominated by medically-oriented psychiatrists who were affiliated with the hospital. Team coordinator at time of study had recently joined the team. Other members joined over the years, including some – such as the peer specialist – who joined more recently.	14	14 (338 pages)	4 (25 pages)	-Team brochure -Team website
Total number		51	55 (1362 pages)	21 (122 pages)	
Other relevant sources consulted	Ontario ACT Standards; Quebec Guidelines Documents; British Columbia Program Standards; Ontario ACT Association website; NCEMH (<i>the National Centre of Excellence in Mental Health</i>) website; Principles of psychiatric rehabilitation; Canadian Centre for Addictions and Mental Health website				

Table 3: Forms of Identity Construction and Counter-institutional Positioning across the Cases

Overall Construction of Team Identity	Recovery or Medical Mode of Operation	Generalist or Specialist Professional Role	Dealing with Stigma and Marginalized Clientele
Alpha: Exemplifying ACT - Exemplary counter-institutional identity - Strong consensus <i>I think we are the best... and I've heard it from several people that we are the best ACT team around. (Team coordinator, Alpha)</i>	Prioritizing recovery model <i>Many of our clients have been beaten down by contact with the mental health system; they've been told what medication to take, how to live...., and often by the time they get to us, they are lacking in self-esteem, even in the ability to dream about what they might want in their life. We help them find a voice, empower them to be effective in their own lives. (Mental health counselor, Alpha)</i>	Prioritizing generalist role <i>I enjoy being a nurse, I enjoy working out of the community health centre, but I'm mostly committed to the team and to the clients. That is absolutely where my loyalties lie and I consider myself an ACT worker almost more than a nurse. (Nurse, Alpha)</i>	Valuing a special role <i>I've worked in hospitals where you look at clients as illnesses with limitations, not with potential. So the difference for me has been a totally different view of clients. (Today) I do not say, "Here's a guy that's been in hospital for 27 years, he's got chronic schizophrenia and he's burned all his bridges in life." (Addictions counselor, Alpha)</i>
Gamma: Becoming ACT - Moving to strong counter-institutional identity - Emerging consensus <i>We have achieved everything that the Guidelines require... We're (now) one of the most exemplary teams in the province. (Team coordinator, Gamma)</i>	Integrating recovery and medical models <i>There is no debate about medical and recovery in our team. Team meetings are a place to talk about medical stuff, [and] equally a place to talk about the recovery stuff. I count on every team member to bring up and participate in both aspects. (Team coordinator, Gamma)</i>	Prioritizing generalist role <i>I am a nurse, but I do everything, beyond this role. I take care of the clients regarding their education, medication, physical health, mental health, I look at the whole dynamic... how they deal with their home, their budget, their food, etc. (Nurse, Gamma)</i>	Valuing a special role <i>If you want to be in a nice office with little flowers, it won't work. You have to be able to walk into a filthy apartment and be at ease in a hostile setting... If that's a trial for you every morning, you won't be able to do this job. (Nurse, Gamma)</i>
Delta: Becoming ACT - Moving to strong counter-institutional identity - Emerging consensus <i>We have attempted to adhere to the Standards quite closely. (Team coordinator, Delta)</i>	Prioritizing recovery model <i>In following the ACT standards, we [different professionals] all work pretty equally on the team. It's not like the hospital at all. We're all really focused on supporting clients to be well – to stay out of hospital and out of jail. (Nurse, Delta)</i>	Prioritizing generalist role <i>I look at a full gamut of care, not just the medical. You're looking at the bio-psychosocial aspect of the client and what are their needs? Where are they at? It may be more appropriate to look at the addictions issues and its social impact - not just the medical. (Nurse, Delta)</i>	Valuing a special role <i>Well we're getting sworn at and having to deescalate people who are very, very agitated and you have to be careful because people are so psychotic... It's very difficult. (Social worker, Delta)</i>
Omega: Approximating ACT - Divergent views on counter-institutional identity - Some dissension <i>Some people would say we're still too medically based and I think there would be a disagreement there. (Occupational therapist, Omega)</i>	Prioritizing medical model but with some dissension <i>The medical model dominates in Omega..., with some conscious movement of many people to incorporate more psychosocial aspects to things that they do. (Team coordinator, Omega)</i>	Prioritizing generalist role <i>We all do a little bit of everything, social work, a little occupational therapy, a little recreation.... We share roles on this team. (Nurse, Omega)</i>	Valuing a special role <i>When you go to see a doctor about something you always come out with a prescription,... So that just gives me the role of making sure that I advocate for the other components of their (clients') life. (Nurse, Omega)</i>

Table 4. Counter-institutional Identity Work in Four Teams

Alpha	Gamma	Delta	Omega
Leader Counter-institutional Identity Work			
<i>Modeling (counter-)institutional identity</i>			
<p><i>Nurse: We made a conscious decision a while back that we were going to move our philosophy away from a medical model towards a recovery model...</i></p> <p><i>Interviewer: Was there a sponsor for this idea?</i></p> <p><i>Nurse: Our peer specialist is one of the leaders in educating us about it. (Nurse, Alpha)</i></p>	<p><i>We have a doctor who really cares about the clients' life projects. (Team coordinator, Gamma)</i></p> <p><i>Our manager played an important role ... She is really applying the ACT standards and that works well. (Social worker, Gamma)</i></p>	<p><i>Whenever it comes to 'we need to develop a procedure on this or that' – we always think, 'what do the Standards say about this topic?' (Team coordinator, Delta)</i></p>	<p><i>Our senior psychiatrist is more stabilization than rehabilitation focused. She tends to want it to be more like a warden "This is what we're going to do with the clients." (Mental health counselor, Omega)</i></p> <p><i>So there's some leadership in terms of the direction we want to go clinically (towards more recovery) from the team coordinator. (Social worker, Omega)</i></p>
<i>Filtering membership to achieve counter-institutional fit</i>			
<p><i>(New hires) need to want to work with other people..., understand the population... And attitudes about mental illness are huge, so (I look at whether) people have pre-formed opinions about clients. (Team coordinator, Alpha)</i></p>	<p><i>I require a written test and an interview with the candidates in the hiring process... Employees who have more seniority in the hospital do not necessarily fit in an ACT team. (Team coordinator, Gamma)</i></p>	<p><i>To work in ACT... it takes the right attitude ... This is not for everyone... If you have a problem with team work, if you are very inflexible regarding your position, if you don't love working with the clients or at least have a big enough empathy, if the vision of your role is very professional..., you won't be happy and neither will you make the team happy. (Team coordinator, Delta)</i></p>	<p><i>We hired in the past year a peer specialist, so someone with lived experience who also brings a recovery focus into team discussions. (Team coordinator, Omega)</i></p>
Group Counter-institutional Identity Work			
<i>Regulating members' counter-institutional identity</i>			
<p><i>From meeting observation notes: Group discussion revolves around a member's practices that showed lack of consideration for previous team decisions, leading to inconsistency in client care – a violation of ACT Standards that emphasize importance of consistency in assistance with activities of daily living to minimize uncertainty for clients. The member apologizes and states that she will read notes in clients' files more diligently before heading out for visits so that consistency is achieved.</i></p>	<p><i>There is a framework that should not be infringed upon and there are rules to respect in our team. Normally, if a rule is broken, the manager intervenes... But sometimes, the team also tries to restore order. For example, we have a rule that no professional should make promises to clients under any circumstances. Recently, a professional infringed on this rule. So during the team meeting, the members pointed it out: "Hey, you have transgressed the rule!" (Social worker, Gamma).</i></p>	<p><i>One of the clinicians was kind of struggling with this one particular client. They would get angry and frustrated with them, and would storm out. At a team meeting, the clinician brought this up – saying "I don't know what to do here." As a team, there was a strong reaction and discussion around how ACT principles set out guidance for how we need to handle situations like this. It was a way for the team to provide guidance for the clinician, showing how you need to do your role on an ACT team. (Team coordinator, Delta)</i></p>	<p><i>From meeting observation notes: A discussion about a client revolves around her asking for more time from ACT team members. Two members are most vocal, one arguing that the team needs to engage more often, given client specific situation. The primary worker responds: "We're supposed to provide care that is progressive and recovery-oriented" and that the way to do so is to be consistent in the approach with this client. The primary worker's view was supported by some of the other members.</i></p>

<i>Bonding around counter-institutional identity</i>			
<i>With the population that we work with, the team aspect allows you not to burn out. If you were alone, having to work with these clients and make these decisions without that built-in consultation, you'd burn out quick. (Mental health counselor, Alpha)</i> <i>We organize a Healthy Lifestyles workshop for clients. [We] presented on that at the ACT conference. When we're successful in something we try to present it to other teams. (Mental health counselor, Alpha)</i>	<i>Our clients are very sick. In an ACT team, the beauty of the thing is that professionals do not carry them (clients) alone. We are 10 professionals for each client. (Team coordinator, Gamma)</i> <i>They (the National Centre of Excellence in Mental Health) wants to conduct a study of exemplary teams and they told us: "You are in the top five teams in Quebec." (Team coordinator, Gamma)</i>	<i>It's a team, like lots of times there... is a lot more discussion that gets you kind of excited about... is this person ready for this, should we be moving him here – what's the best plan. (Life skills specialist, Delta)</i> <i>We attended a workshop with other ACT teams around the country, and we started to realize that we were doing ACT a lot better than many others. (Addictions Counselor, Delta)</i>	<i>From meeting observation notes: A mental health counselor reports on Client X whose wheelchair needs repairs but the client cannot afford the cost. The counselor does not know what to do. Others provide suggestions, including applying to a government program that provides aid for assistive devices.</i>
Individual Member Counter-institutional Identity Work			
<i>Reframing counter-institutional roles</i>			
<i>We get these clients that have been sort of isolated or cast off in a sense, get them back into the mainstream society and get them accessing their rights. (Addictions counselor, Alpha)</i>	<i>Our team is very different from other mental health teams. We do not work in the hospital, we have weird clients... It's work that makes no sense! We see houses that make no sense. All that is very emotionally demanding... not everyone can do it... You need to be a little bit special to work in an ACT team. (Physician, Gamma)</i>	<i>I remember a team meeting where we were discussing a difficult person, and I thought we should enforce all the rules more strictly. But a couple of the more experienced nurses responded with reasons why we need to be malleable, we have to do what works for the client that day. I learned a lot about how to be part of this team. (Nurse, Delta)</i>	<i>Others think mental health consumers are just exaggerating, and if something is going on, it's because it's related to psychosis... Sometimes there are peer-professionals that don't disclose... I thought, I'm going to identify myself and be upfront about this because I think I can take that on. (Peer specialist, Omega)</i>
<i>Self-selecting in or out of the counter-institution</i>			
<i>There's a good match for me; ... I need to have a job where I feel like I can make a difference in somebody's life... I wrote my exposition for my application for graduate school talking about contrasting medical model versus non-medical model and how that fit my philosophy. (Mental health counselor, Alpha)</i>	<i>A social worker left after a year because she was unable to conform to requirements of the generalist role: I am more a social worker than an ACT member. I know that I won't have a career in an ACT team. (Social worker, Gamma)</i>	<i>I'm really making a lot of progress with him [a particular client] and that's why I'm here on this team, right? Whatever way you can make a difference in somebody's life, to help move them forward and be successful, whatever that success may be for that person, that's why I'm here and that's why I love the work I do. (Nurse, Delta)</i>	<i>It's an ACT team, our roles are intermeshed, so we all do basically the same role. I am in the right place at the right time on this team. (Nurse, Omega)</i>

Table 5: Mapping Counter-Institutional Identity Work Practices³

	Oppositional Identity Work	Relational Identity Work
Leaders (carriers of professional, administrative and normative authority)		Modeling
Group		Bonding
Individual members		Reframing
Role with respect to foil of dominant institution	Controlling: Excluding values, roles, practices and people of dominant institution from the group	Supporting: Constructing counter-institutional values, roles, practices as superior to foil within the group

³ Dotted lines in the table are intended to recognize that leaders and members also participate in the group.

Figure 1: The Dynamics of Counter-Institutional Identity Construction and Maintenance

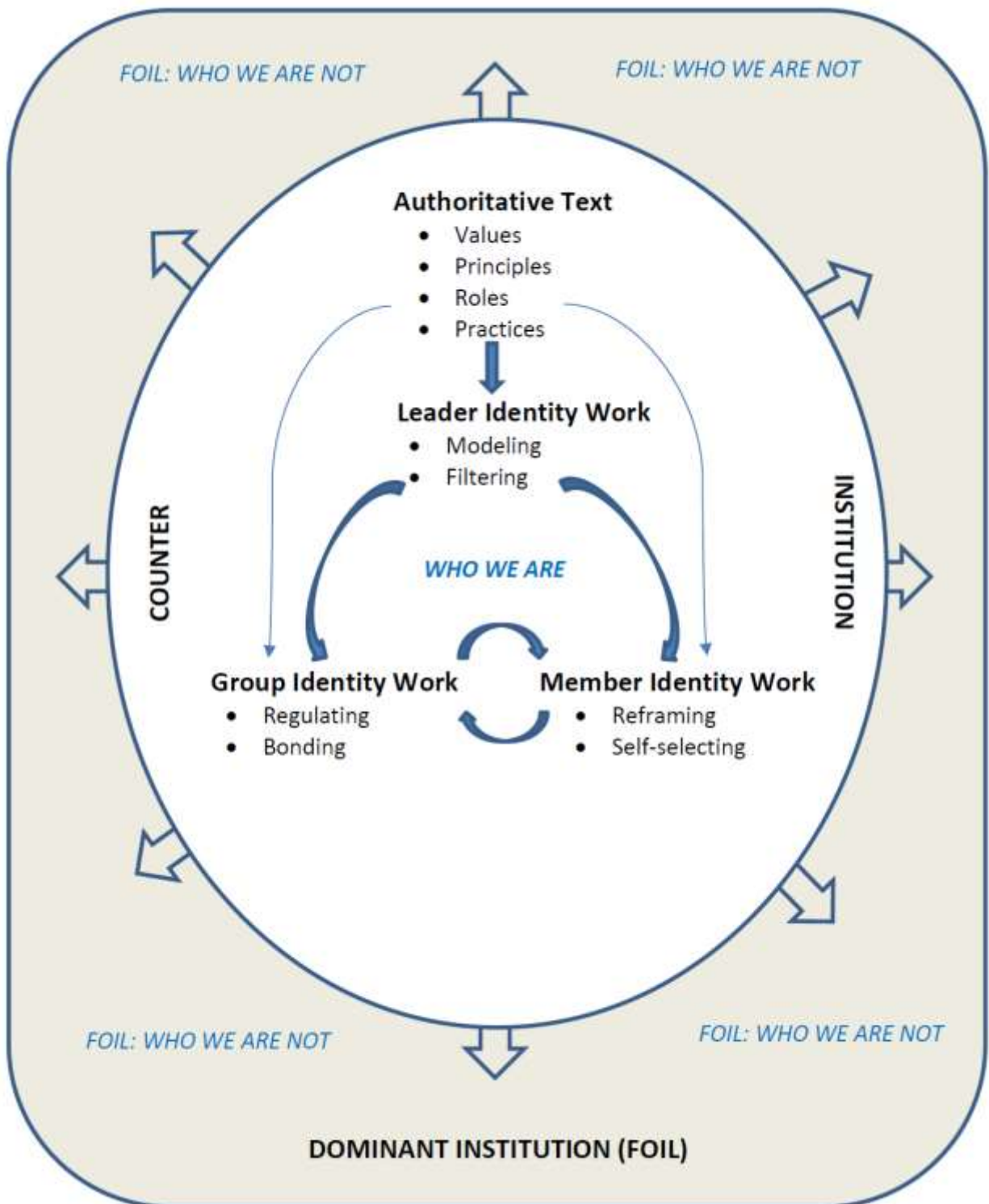


Figure 2: Patterns of Counter-Institutional Identity Work in Four ACT Teams

